Valley County Health System
Financial Assistance Application Form

Please note Valley County Health System may access external validation resources to assist in determining whether a full application for assistance is required.

Patient Name	Social Security #	Date of Birth	Account(s) Number
Spouse's Name (if applicable)	Social Security #	Date of Birth	Home Phone #
Address, City, State, Zip		Length of Residence	Cell Phone #(s)
Previous Address, City, State, Zip (if less than 2 years at above)		Marital Status	# of Dependents in Household
List Name(s) & Age(s) of Dependent(s) in Household			

Have you applied for Medicaid or any other State/County Assistance? ☐ Yes ☐ No	Application Date	Status of application
If you have applied for assistance, please do not continue to complete any additional sections of them. Please contact a patient financial services representative for additional information at (308) 728-4231 or (308) 728-4350.		

Patients Employer's Name		Address, City, State, Zip		
Job Title	Length of Employment	Business Telephone #	Hourly Rate	Monthly Income Gross

Patients PREVIOUS Employer's Name		Address, City, State, Zip		
Job Title	Length of Employment	Business Telephone #	Hourly Rate	Monthly Income Gross

Spouse's Employer's Name		Address, City, State, Zip		
Job Title	Length of Employment	Business Telephone #	Hourly Rate	Monthly Income Gross

	Other Income Source	Dollar Amount	
1)		$	Ex: Social Security, Disability, Unemployment, Spousal/Child Support, Rental Property
2)		$	
3)		$	

	Bank Name	Dollar Amount	
1)		$	Ex: Checking, Savings, Health Savings, Money Market (Please attach Statements)
2)		$	
3)		$	

Automobile(s)	Make	Year	Monthly Payment	Balance Due
1)			$	$
2)			$	$
3)			$	$

	Other Assets	Dollar Amount	
1)		$	Ex: Mutual Funds, Stocks, Bonds (Please attach Statements) and Property, Boat, Business, Farm Equipment etc
2)		$	
3)		$	

Are you a Homeowner? ☐ Yes ☐ No	Approximate $ Value	Balance on Loan	Years Left on Loan

Monthly Expenses:

Description	Payment to	Monthly Payment	Balance Due
Rent/Mortgage		$	$
Credit Card		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
Medical Bills		$	$
Food		$	$
Utilities		$	$
Gas (Car)		$	$
Auto Insurance		$	$
		$	$
		$	$

Supporting documentation needed: Complete Tax Return, W-2, 3 most recent pay stubs, 3 months of bank statements, denial letter from Medicaid. Additional information may be requested. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

CERTIFICATION

1. I, The undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Valley County Health System, information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Valley County Health System to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)	Date
Signature (Spouse)	Date